

# Application for ALS Agency To Engage in Controlled Substances Activity for Pre-Hospital Care

Submit application and all required attachments in triplicate. Print or type neatly. Incomplete applications will be returned.

<input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL		Controlled Substances License No: _____ Expiration: _____	NYS EMS Agency Code _____	NYS EMS Cert. Expiration: _____
Name of Agency _____			Federal Employer ID No. _____	
Physical address of principal business location (street and no.) _____			Mailing Address (PO Box) _____	
City, Town, Village _____		State _____	Zip _____	County _____
Business Phone No. _____	Service Type: <input type="checkbox"/> Ambulance <input type="checkbox"/> First Responder			

Organizational Structure (Check only one) <input type="checkbox"/> Proprietary <input type="checkbox"/> Industrial <input type="checkbox"/> Vol. Independant				
<input type="checkbox"/> Hospital <input type="checkbox"/> Government / Municipal <input type="checkbox"/> Vol. Fire Dept. <input type="checkbox"/> Other _____				
Type of Ownership (check only one) <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Government <input type="checkbox"/> Corporation				
Name of Individual Owner, Partners, Corporation or Government entity : _____				
Level of Service provided by Agency (Check highest) <input type="checkbox"/> EMT - Critical Care <input type="checkbox"/> EMT - Paramedic				

Name of Agency CEO _____		Title _____	
Business Address _____		Mailing Address (PO Box) _____	
City, Town, Village _____	State _____	Zip _____	Business Phone No. _____ Home Phone No. _____

Name of Controlled Substance Agent appointed by Agency _____		NYS AEMT # and Cert Level <input type="checkbox"/> CC <input type="checkbox"/> P	NYS AEMT Expiration _____
Street Address _____		Mailing Address (PO Box) _____	
City, Town, Village _____	State _____	Zip _____	Business Phone No. _____ Home Phone No. _____

Name of System Medical Director providing Medical Control _____		DEA Number _____	NYS License No. _____
Business Address _____		Mailing Address (PO Box) _____	
City, Town, Village _____	State _____	Zip _____	Business Phone No. _____ Home Phone No. _____

Name of Organization providing Medical Control to Agency _____		Contact Person _____	
Mailing Address and Physical Location _____		Title _____	
City, Town, Village _____	State _____	Zip _____	Business Phone No. _____

Name of Contracting Hospital or Source of Controlled Substances _____		Contact Person _____	
Mailing Address and Physical Location _____		Title _____	
City, Town, Village _____	State _____	Zip _____	Business Phone No. _____ DEA Number _____


**List of Attachments and Supporting Documents**

<input type="checkbox"/> Controlled Substances Plan (80.136.f.4)	<input type="checkbox"/> QA Plan for Controlled Substances (80.136.f.5)
<input type="checkbox"/> Controlled Substance Supplier Agreement	<input type="checkbox"/> All Locally Developed Forms/Documents
<input type="checkbox"/> Protocol(s) for Controlled Substances Administration	

**Medical Director's Affirmation**

I have read and understand the content of 80.136 and agree to act as this agency's Medical Director. I understand my responsibilities relative to this application and hereby approve this agency's use of controlled substances under my medical direction.

Name of Medical Director	Signature of Medical Director	Date
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**PART 80 Controlled Substances Applicant Certification**

By signing this application I certify that:

1. I have read and understand the contents and responsibilities of Public Health Law Articles 30 and 33, the State EMS Code (10NYCRR Part 800) and Controlled Substances Regulations (10NYCRR Part 80)
2. All information on this application is true and correct
3. I or any named owner or responsible individual under the provisions of this part have never been convicted of a felony.
4. I accept the responsibilities as provided in 80.136(k)
5. I will insure all provisions and requirements of the part are understood and implemented by any person under my charge.
6. I will instruct all persons under my charge with their responsibilities with regard to storage, access, safeguarding of controlled substances and the reporting of any misuse or diversion.
7. I understand that any misrepresentation or falsification of this application is grounds for annulment, suspension, limiting or revocation of this article 33 license and may make me and the EMS Agency subject to further action by the New York State Department of Health.

Name of Agency CEO	Signature of Agency CEO	Date
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**Notary Public**

Affirmation & Acknowledgment  
For Agency CEO Only

**For DOH use only**

**EMS**

**Approved**

**Date**

**BCS**

**Approved**

**Date**